DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
			B. WIN			08/15/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				YNTREE DR		
BELL ∩∧	KS TERRACE			1	JRGH, IN47630		
				INLVVD			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
			1				
	This visit was for	r Investigation of	R(0000	Submission of this response		
	Complaints IN00094368, IN00094485,				Plan of Correction is NOT a I	-	
	IN00094417, and IN00094001.				admission that a deficiency e	exists	
					or, that this Statement of		
		204260 0 1 4 2 2 3			Deficiencies was correctly cit		
	*	094368 - Substantiated.			and is also NOT to be constr		
	State residential deficiencies related to the allegations are cited at R116, R117, R119, and R145. Complaint IN00094485 - Substantiated.				as an admission against inte by the residence, or any	ાદરા	
					employees, agents, or other		
					individuals who drafted or ma	av be	
					discussed in the response or	-	
					of Correction. In addition,		
	State residential deficiencies related to the allegations are cited at R90, R91, and				preparation and submission	of	
					this Plan of Correction does	NOT	
					constitute an admission or		
	R121.				agreement of any kind by the		
					facility of the truth of any fact		
	Complaint IN000	94417 - Substantiated.			alleged or the correctness of	any	
	*	deficiencies related to the			conclusions set forth in this		
					allegation by the survey ager	ıcy.	
	allegations are ci	ted at 145.					
	Complaint IN000	994001 - Substantiated.					
	State residential	deficiencies related to the					
	allegations are ci	ted at R144 and R145.					
	Unrelated deficie	unaisa sitad					
	Uniterated deficie	encies cited.					
	Survey dates: 8/1	1, 8/12, and 8/15/11					
	Facility number:	004903					
	Provider number						
	AIM number: N/						
	Alivi liumber: N/.	A					
	Survey team: Jei	nnie Bartelt, RN					
					<u> </u>		
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C7RY11

Facility ID:

004903

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING B. WING	00		e survey pleted /2011
	PROVIDER OR SUPPLIEF		4200 W	ADDRESS, CITY, STATE, ZIP CO YNTREE DR JRGH, IN47630	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	REGULATORY OR Census bed type Residential: 46 Total: 46 Census payor typ Other: 46 Total: 46 Sample: 15 These state resid in accordance with	tential findings are cited ith 410 IAC 16.2-5. ompleted 8/19/11	l I	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	HOULD BE	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			1		08/15/2011
			B. WING	A DDDDEGG CHEV CEATE THE CODE	
NAME OF P	ROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE	
			l l	VYNTREE DR	
BELL OA	KS TERRACE		NEWB	URGH, IN47630	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROUDERIG BY AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R0090		tor is responsible for the			
K0090		ent of the facility. The			
		the administrator shall			
	•	ot limited to, the following:			
		livision within twenty-four			
		ming aware of an unusual			
		rectly threatens the welfare,			
		f a resident. Notice of			
	•	e may be made by			
		d by a written report, or by a			
	•	that is faxed or sent by			
		he division within the			
		our time period. Unusual			
		de, but are not limited to:			
	(A) epidemic outbr				
	(B)poisonings;				
	(C) fires; or				
	(D) major accident	is.			
		not be reached, a call shall			
		nergency telephone number			
	published by the d				
		ging for or assisting with the			
		al, dental, podiatry, or			
		ner health care services as			
	_	esident or resident's legal			
	representative.	•			
	(3) Obtaining direct	ctor approval prior to the			
	admission of an in	dividual under eighteen (18)			
	years of age to an	adult facility.			
	(4) Ensuring the fa	acility maintains, on the			
	premises, an accu	rate record of actual time			
	worked that indica	tes the:			
	(A) employee's full	name; and			
	(B) dates and hou	rs worked during the past			
	twelve (12) months	S.			
		sults of the most recent			
	annual survey of the	he facility conducted by			
		ny plan of correction in			
		to the facility, and any			
	subsequent survey	ys. The results must be			
		ination in the facility in a			
	place readily acces	ssible to residents and a			

004903

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	IG		08/15/2	U11
NAME OF	PROVIDER OR SUPPLIEI	?	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	YNTREE DR		
BELL OA	AKS TERRACE			NEWBU	JRGH, IN47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	notice posted of the						
	(6) Maintaining reports of surveys conducted by the division in each facility for a period of						
		making the reports available					
		any member of the public					
	upon request						
		review and interview, the	R(0090	Citation #1 R 090 410 IAC		09/20/2011
	•	ensure the Administrator			16.2-5-1.3 (g) (1-6) Administration and		
	reported an alleg	gation of abuse to the			Management What correcti	ve	
	State agency, as	required in facility policy,			action(s) will be accomplis		
	for 1 of 1 resident alleged to have been				for those residents found to		
abused in a sample of 15. (Resident G)					have been affected by this		
Findings include:				deficient practice? No resid	ents		
				were found to be affected.			
					Resident G's incident was reported onto the Indiana St	ate	
	During confiden	tial interview on 8/11/11,			Department of Health by the		
	_	indicated hearing			Designee appointed by the		
		4 verbally threaten			Residence Director. An	_	
	1 ^	e providing care.			investigation was completed the alleged event and was fo		
		o providing out.			to be unsubstantiated.	Juliu	
	The hospice clin	ical record for Resident G			Arrangements were made for	r an	
	_	n 8/12/11 at 1:00 p.m.			alternative caregiver to provi	de	
		on the Hospice Aide Visit			services to this Resident G.		
		he resident was provided			How the facility will identify other residents having the	'	
		Hospice Aide #4 on 7/4,			potential to be affected by	the	
		7/25, and 8/1/11. The			same deficient practice and		
		outine personal care was			what corrective action will		
		*			taken? No other residents w	ere	
	1 ^	dates except on the note			found to be affected. What		
	for 7/25/11. A notation on that date indicated, "Pt [patient] was on the floor when I came into room to do care. He				measures will be put into p		
					or what systemic changes the facility make to ensure		
					the deficient practice does		
		due to not feeling well			recur? The Residence Direct		
	from being on fl	oor for awhile."			and Wellness Director were		
					re-educated to the Indiana s		
	During interview	v on 8/12/11 at 1:15 p.m.,			ruling 090 410 IAC 16.2-5-1.	3 (g)	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4200 WYNTREE DR **BELL OAKS TERRACE** NEWBURGH, IN47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE upon request for files of allegations of (1-6) Administration and Management and our policy and abuse, Residence Director (RD) #2, who procedure regarding the Assisted was from a sister facility and filling in for Living Decision requirements as RD #1 that day, indicated she had to reporting of incidents. How will contacted RD #1, a corporate the corrective action(s) will be monitored to ensure the representative filling in as Residence deficient practice will not recur. Director until Residence Director #3 i.e., what quality assurance becomes a licensed Health Facility program will be put into place? Administrator. RD #2 indicated RD #1 The Wellness Director or told her the facility had received no Designee will perform an ongoing daily review of incident reports allegations of abuse. per our policy regarding the ALC Decision Tree for a period of six During interview on 8/12/11 at 2:05 p.m., months to ensure incidents are RD #2 was advised of the allegation of reported to the appropriate individuals and state agencies verbal threatening of Resident G. RD #2 within twenty four (24) hours of indicated she would investigate the the occurrence as defined within allegation and provide the facility's policy Indiana state ruling 090 410 IAC related to allegations of abuse. 16.2-5-1.3 (g) (1-6) Administration and Management. Audits will be During interview on 8/12/11 at 4:20 p.m., reviewed after six months through RD #2 indicated she had talked with the Bell Oaks Terrace QA process to Marketing Director about the allegation. determine the need for an ongoing monitoring plan. RD #2 indicated she was told the former Findings suggestive of Wellness Director (WD #2) had come to compliance will result in cessation the Marketing Director's office on an of our monitoring plan. By what unidentified date and told the Marketing date will the systemic changes Director that Hospice Aide #4 had be completed? Compliance Date: Sept 20, 2011 threatened Resident G. RD #2 indicated the Marketing Director told RD #2 she had talked with Hospice Aide #4 about the allegation and learned the following: Hospice Aide #4 told the Marketing Director Resident G raised his fist and threatened her, and Hospice Aide #4 said

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC		i .	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	l	LETED
			B. WING		08/15/	2011
NAME OF I	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD	DE .	
			I	YNTREE DR		
BELL OA	AKS TERRACE		NEWBU	URGH, IN47630		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)		DATE
		ful but firm with Resident				
	_	in order to care for the				
	_	te Aide #4 indicated she				
		nage the resident, since				
		facility employee. RD				
		spice Aide #4 had been at				
		is date, 8/12/11, to				
	1 *	D #2 indicated the tor said she told the				
		should report to RD #1 if				
	she still had concerns about the allegation. RD #2 indicated neither the Marketing					
		•				
	Director nor WD	-				
	allegation of abu					
	1 -	the allegation was made,				
	1	n was not reported to the				
	1 .	D #2 indicated if an RD				
		ng, the WD would be in				
	charge of receiving	ng allegations of abuse.				
	The employee fi	le for WD #2 was				
		1/11 at 1:30 p.m. The file				
		D's date of hire was				
		entation failed to indicate				
		orientation related to				
		cedures related to resident				
	1	nterview on 8/11/11 at				
	1	gard to employees, RD				
) #2 was on staff from				
		7/11, when she did not				
	return to work.	11, when one did not				
	Totalii to work.					
	The facility's Sus	snected				
		Exploitation policy was				
	1 10 usc/1 vegicet/1	Apronation policy was				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE :	
			A. BUII B. WIN			08/15/2	
	PROVIDER OR SUPPLIER		p. wnw	STREET A	DDRESS, CITY, STATE, ZIP CODE YNTREE DR JRGH, IN47630	<u> </u>	
	SUMMARY S (EACH DEFICIENT REGULATORY OR Provided by RD p.m. The policy complaints of ab exploitation shows arious and must Residence Direct Director of Operabuse, neglect, or resident is suspect protect the resident harmCall your Regional Director assistance as soo quickly to gather information6. Report and make documentation in Notes. 7. Initiates staff on duty at the occurred must be leaving their respinstruction from or Regional Director contact the approximation as possible reporting timefra	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) #2 on 8/12/11 at 4:20 included, "1. Any use, neglect or ald be viewed as very be reported to the tor and the Regional ations immediately4. If r exploitation of a cted, act immediately to cent from additional Residence Director and or of Operations for n as possible. 5. Act r pertinent Complete an Incident		4200 W	YNTREE DR	NTE .	(X5) COMPLETION DATE
	abuse"	suspected or alleged ntial finding is related to 094485.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BELL OAKS TERRACE			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	JRGH, IN47630 I	(X5)		
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
R0091	a written policy may care and facility of attained, to include (1) The range of s (2) Residents' right (3) Personnel adm (4) Facility operation The policies shall residents upon real Based on intervious facility failed to procedure for procedure for procedure for procedure for procedure for 1 of alleged to have be sample of 15. (Findings included During confident the interviewee in Hospice Aide #4 Resident G while The hospice clin was reviewed on	e the following: ervices offered. ths. ninistration. ons. be made available to quest. ew and record review, the implement policy and otecting residents' rights gation of abuse of a 1 resident who was been threatened in a Resident G) : tial interview on 8/11/11, ndicated hearing 4 verbally threaten	R0091	Citation #2 R 091 410 IAC 16.2-5-1.3 (h) (1-4) Administration and Management What correcti action(s) will be accomplis for those residents found t have been affected by this deficient practice? No resid were found to be affected. Resident G's incident was reported onto the Indiana St Department of Health by the Designee appointed by the Residence Director. An investigation was completed the alleged event and was for to be unsubstantiated. Arrangements were made for alternative caregiver to proviservices to this Resident G. How the facility will identify	hed o		

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Event ID:

C7RY11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4200 WYNTREE DR **BELL OAKS TERRACE** NEWBURGH, IN47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Note indicated the resident was provided other residents having the potential to be affected by the personal care by Hospice Aide #4 on 7/4, same deficient practice and 7/11, 7/12, 7/18, 7/25, and 8/1/11. The what corrective action will be notes indicated routine personal care was taken? No other residents were provided on all dates except on the note found to be affected. What for 7/25/11. A notation on that date measures will be put into place or what systemic changes will indicated, "Pt [patient] was on the floor the facility make to ensure that when I came into room to do care. He the deficient practice does not refused all care due to not feeling well recur? The Residence Director from being on floor for awhile." and Wellness Director were re-educated to the Indiana State ruling R 091 410 IAC 16.2-5-1.3 During interview on 8/12/11 at 1:15 p.m., (h)(1-4) Administration and upon request for files of allegations of Management and our policy and abuse, Residence Director (RD) #2, who procedure regarding The Assisted Living Decision. How will the was from a sister facility and filling in for corrective action(s) will be RD #1, indicated she had contacted RD monitored to ensure the #1, a corporate representative filling in as deficient practice will not recur, Residence Director until Residence i.e., what quality assurance Director #3 became licensed. RD #2 program will be put into place? indicated RD #1 told her the facility had The Wellness Director or Designee will perform an ongoing received no allegations of abuse. daily review of resident incident reports per our policy and During interview on 8/12/11 at 2:05 p.m., procedure regarding the ALC RD #2 was advised of the allegation of Decision Tree for a period of six months to ensure incidents are verbal threatening of Resident G. RD #2 reported to the appropriate indicated she would investigate the individuals and state agencies allegation and provide the facility's policy within twenty four (24) hours of related to allegations of abuse. the occurrence as defined within Indiana state ruling 090 410 IAC 16.2-5-1.3 (g) (1-6) During interview on 8/12/11 at 4:20 p.m., Administration and Management. RD #2 indicated she had talked with the The Wellness Director and/or Marketing Director about the allegation. Residence Director will review incidents to ensure resident rights She indicated the Marketing Director told are protected against alleged her the former Wellness Director (WD #2)

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S	
			B. WIN			08/15/20	011
	PROVIDER OR SUPPLIER		•	4200 W	.ddress, city, state, zip code YNTREE DR JRGH, IN47630	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	office and told the Hospice Aide #4 G. RD #2 indicated Director told RD Hospice Aide #4 learned the follow told the Marketir raised his fist and Hospice Aide #4 but firm with Resorder to care for Aide #4 indicated manage Resident former facility er indicated Hospic facility on this data care. RD #2 indicated Director said she should report to a concerns about the indicated neither nor WD #2 report abuse to RD #1, allegation was more reported #2 indicated if the building, the WD receiving allegation	e Aide #4 had been at the ate, 8/12/11, to provide icated the Marketing told the former WD she RD #1 if she still had he allegation. RD #2 the Marketing Director ted the allegation of no investigation of the ade, and the allegation to the State agency. RD e RD was not in 0 would be in charge of ions of abuse.			occurrences of abuse throug internal investigation with necessary provisions made protect our residents agains alleged violations of their resights. Audits will be reviewe after six months through Bel Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cess of our monitoring plan. By will date will the systemic chambe completed? Compliance Date: Sept 20, 2011	as to t sident d I sation hat	
	reviewed on 8/11 indicated the WI	le for WD #2 was /11 at 1:30 p.m. The file D's date of hire was entation failed to indicate					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	08/15/2	
			B. WINC			00/13/2	011
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
BELL OA	AKS TERRACE				YNTREE DR JRGH, IN47630		
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PREFIX	· `	NCY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	orientation related to					
	1 * *	cedures related to resident					
	1	nterview on 8/11/11 at					
	_	egard to employees, RD					
	1) #2 was on staff from					
	1	27/11, when she did not					
	return to work.						
	The facility's Suspected						
	Abuse/Neglect/I	Exploitation policy was					
	provided by RD #2 on 8/12/11 at 4:20						
	p.m. The policy included, "1. Any						
	complaints of ab	ouse, neglect or					
	exploitation sho	uld be viewed as very					
	serious and mus	t be reported to the					
	Residence Direc	tor and the Regional					
	Director of Open	rations immediately4. If					
	abuse, neglect, o	or exploitation of a					
	resident is suspe	cted, act immediately to					
	protect the resid	ent from additional					
	harmCall you	r Residence Director and					
	Regional Direct	or of Operations for					
	assistance as soc	on as possible. 5. Act					
	quickly to gathe	r pertinent					
	information6.	Complete an Incident					
	Report and make	e appropriate					
	documentation i	n the resident's Service					
	Notes. 7. Initiate an investigation. All						
	staff on duty at t	he time the alleged abuse					
	occurred must b	e interviewed prior to					
	leaving their res	pective shift8. Upon					
	instruction from	your Residence Director					
		ector of Operations,					
	contact the appr	opriate State agency as					

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	PROVIDER OR SUPPLIER		STREET A 4200 W	ADDRESS, CITY, STATE, ZIP CODE /YNTREE DR URGH, IN47630	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0116	reporting timefra resident's family/ physician of the sabuse" This state resider Complaint IN000 (a) Each facility shall have a considers reference accordance with 10 Based on record facility failed to references were comployees for 5 hired and termina since 4/22/11. (R CNA #1, CNA #3, CNA #4, CNA #4, CNA #4, The deficient practices of the same content of th	hall have specific procedures hented for the screening of yees. Appropriate inquiries prospective employees. The a personnel policy that hes and any convictions in C 16-28-13-3. Treview and interview, the ensure employment checked for prospective of 7 former employees hated from employment IN Wellness Director #1, 3, Personal Service IN Wellness Director #2) cotice had the potential to esidents at the facility.	R0116	Citation #3 R 116 410 IAC 16.2-5-1.4 (a) Personnel Will corrective action(s) will be accomplished for those residents found to have be affected by this deficient practice? No residents were found to be affected. Emplo files were reviewed for curre employees with reference completed and placed within file. How the facility will ide other residents having the potential to be affected by same deficient practice an what corrective action will	een e yee ent hecks n their entify the

STRUCT ADDRESS. CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII B. WING		00	(X3) DATE S COMPL 08/15/2	ETED
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During Entrance Conference with Residence Director (RD) #1 on 8/11/11 at 10:30 a.m., files of employees terminated, either voluntarily or involuntarily, since 4/1/11 were requested. During interview on 8/11/11 at 10:30 a.m., RD #1 provided files of seven employees terminated since 4/1/11. Review of the files at this time indicated employment or personal references were not checked on the following employees prior to employment: 1. RN Wellness Director #2, date of hire 7/21/11. 2. CNA #1, date of hire 6/22/11. 3. CNA #3, date of hire 6/8/11. 4. PSA (Personal Services Assistant) #1, date of hire 6/10/11. 5. RN Wellness Director #1, date of hire 5/2/11. During interview at this same time, RD #1 indicated she was the Regional Residence Director for fourteen facilities in her corporation, including residences in	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
Tennessee, Kentucky, and Indiana. She indicated the RD from Bell Oaks had been transferred to another facility and had Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan.	TAG	During Entrance Residence Direct 10:30 a.m., files either voluntarily 4/1/11 were reque During interview a.m., RD #1 prove employees termi Review of the file employment or provent of the checked on the prior to employee 1. RN Wellness 7/21/11. 2. CNA #1, date 3. CNA #3, date 4. PSA (Personal date of hire 6/10) 5. RN Wellness 5/2/11. During interview indicated she was Director for four corporation, inclusted the RD indicated the RD indicated the RD indicated the RD indicated indicated the RD indicated indicated the RD indicated indicated the RD indicated indicated indicated indicated indicated the RD indicated indic	Conference with tor (RD) #1 on 8/11/11 at of employees terminated, or involuntarily, since ested. Ton 8/11/11 at 10:30 wided files of seven nated since 4/1/11. The sat this time indicated personal references were the following employees ment: Director #2, date of hire To hire 6/8/11. Il Services Assistant) #1, 1/11. Director #1, date of hire To at this same time, RD #1 as the Regional Residence teen facilities in her unding residences in acky, and Indiana. She of from Bell Oaks had been	T	AG	taken? No other residents we found to be affected. Employ files were reviewed for curre employees with reference of completed and placed within file. What measures will be into place or what systemic changes will the facility may to ensure that the deficient practice does not recur? The Residence Director and Well Director were re-educated to policy and procedure regard new employee paperwork all with completion of reference background checks for prospective employees prior hire. The Residence Director Wellness Director, and/or Designee will be responsible completing reference checks new employees prior to reside contact. How will the correct action(s) will be monitored ensure the deficient practic will not recur, i.e., what qual assurance program will be into place? The Residence Director and/or Designee will perform a random monthly and of employee files for a period six months to ensure criminal background and reference checks are completed on prospective employees as indicated within our policy ar procedure. Audits will be reviewed after six months the Bell Oaks Terrace QA proceed determine the need for an	rere /ee /nt necks intheir put /eke /ne /necks intheir put /eke /ne /necks /eke /ne /necks /	DATE

004903

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING B. WING	00 	COMP 08/15/2	LETED
	PROVIDER OR SUPPLIER		4200	raddress, city, state, zip WYNTREE DR BURGH, IN47630	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAG	subsequently left employment. Sh provisional Heal Administrator's I had been filling if four months. Sh for fourteen hom up. During this s indicated PSA #1 terminated but w related to unusual would probably I	the company's e indicated she had a th Facility icense for Indiana and n at Bell Oaks for about e indicated as consultant es, it was hard to keep same interview, RD #1 had not actually been as suspended recently al behavior, and that he be terminated.	TAG	Findings suggestive compliance will result of our monitoring place date will the system be completed? Corn Date: Sept 20, 201	ult in cessation an. By what mic changes mpliance	DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	O0	(X3) DATE SURVEY COMPLETED 08/15/2011
	PROVIDER OR SUPPLIER		4200	ET ADDRESS, CITY, STATE, ZIP CODE WYNTREE DR /BURGH, IN47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0117	qualifications, and applicable state la twenty-four (24) he unscheduled need services provided. and training of star required to provide the residents. A m staff person, with certificates, shall be (50) or more residential administration of none (1) nursing stall times. Resident hundred (100) res residential nursing of medication, or be (1) additional nursion duty at all times (50) residents. Per only those duties of perform. Employed written job descripts Based on record facility failed to qualified for 2 of work schedule for (LPNs #1 and #2 nursing assistants schedule. (CNAs #11, #12, #13, and failed to ensure the was licensed who former RN Wellry Wellness Directors.	The number, qualifications, if shall depend on skills of for the specific needs of inimum of one (1) awake current CPR and first aid the on site at all times. If fifty ents of the facility regularly nursing services or nedication, or both, at least aff person shall be on site at atial facilities with over one idents regularly receiving services or administration both, shall have at least one ing staff person awake and of for every additional fifty resonnel shall be assigned or which they are trained to be duties shall conform with	R0117	Citation #4 R 117 410 IAC 16.2-5-1.4 (b) Personnel W corrective action(s) will be accomplished for those residents found to have be affected by this deficient practice? No residents were found to be affected. Emplo files were reviewed with verification provided as to the current employee licensure status. How the facility will identify other residents had the potential to be affected the same deficient practice what corrective action will	een e yee yee eir ving I by e and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7RY11 Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
			B. WING			08/15/2	011	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE			
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BELL OF	AKS TERRACE			NEWBC	JRGH, IN47630			
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PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL						
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY) DA			
	46 residents at the	ne facility.			taken? No residents were fo	und		
		-			to be affected. Employee file			
	Findings include	· ·			were reviewed with verification	on		
	i manigs merade				provided as to their current			
		00 1 1 1 0 7/01			employee licensure status. V			
	I -	ffing schedule for 7/31			measures will be put into p			
	through 8/13/11	was provided by			or what systemic changes			
	Residence Direc	tor (RD) #1 at the			the facility make to ensure			
	completion of th	e Initial Tour on 8/11/11			the deficient practice does recur? The Residence Direction			
	_	ursing staff scheduled to			and Wellness Director were	lOI		
		•			re-educated to our policy and	4		
	work or observed working at the facility				procedure regarding new	4		
	during this time frame included the				employee paperwork along v	vith		
	1	s #1 and #2, CNAs #5,			completion of licensure			
	#6, #7, #8, #9, #	10, #11, #12, #13, and			verification for prospective			
	#14.				employees. The Residence			
					Director and/or Designee wil			
	 During interview	v on 8/12/11 at 11:40			responsible for ensuring licer	nsure		
	_				verification is obtained for			
		o was from a sister			employees and placed within	their		
	1 *	ng in for RD #1 on that			prospective employee file.	()		
	1 -	her facility she had all			How will the corrective action will be monitored to ensure the			
	information on 1	icensing and certification			deficient practice will not recu			
	of nursing staff i	n a book with current			i.e., what quality assurance	1,		
	licensing inform	ation. RD #2 indicated			program will be put into place	?		
	_	to locate the information			The Residence Director and/or			
		D #2 provided internet			Designee will perform a randon	n		
		-			monthly audit of employee files			
	_	8/12/11, indicating all			period of six months to ensure s	taff		
	staff listed were	licensed or certified.			have verification of active India	ına		
					licensure within their employee	file.		
	RD #2 also prov	ided the following:			Audits will be reviewed after si			
	_	-			months through Bell Oaks Terra			
	1 For LPN #1	a printout indicating the			QA process to determine the ne	ed for		
		information was checked			an ongoing monitoring plan.			
					Findings suggestive of compliant	nce		
	1	and copy of a license card			will result in cessation of our			
		cense expired on 10/31 of			monitoring plan			
	even years. The	nurse worked from			By what date will the systemic			

004903

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
			A. BUI B. WIN	LDING		08/15/2	2011
NAME OF T	ADOLUDED OF GUIDA TO	<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	{			YNTREE DR		
BELL OA	KS TERRACE			NEWBL	JRGH, IN47630		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	FICIENCY MUST BE PERCEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
IAG		/12/11 without evidence		IAG	changes be completed?		DAIL
	of current LPN 1				Compliance Date: Sept 20, 20	011	
		iconsc.					
	2. For former er	nployee RN Wellness					
	Director #1, with	n date of hire 5/2/11, a					
	•	ng the nurse's license was					
		on $6/8/11$, and copy of a					
		cating the license expired					
		years. The RN Wellness					
		5/2/11 through 6/8/11					
	without evidence	e she was a licensed RN.					
	3 For LPN #2	a printout indicating the					
		information was checked					
	_	and copy of a license card					
		cense expired on 10/31 of					
		nurse worked from					
		/12/11 without evidence					
	of current LPN 1	icense.					
		copy of a licensing card					
	•	inted five times per					
		columns on the card. No					
		ndicated CNA #9 was					
	_	the on-line printout					
	dated 8/12/11.						
	This state reside	ntial finding is related to					
	Complaint IN00	•					

STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
AND I LAN	or conduction	DENTIFICATION NOVIDER.	A. BUILDING	00			
			B. WING		08/15/2011		
NAME OF I	PROVIDER OR SUPPLIEI		STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	I KO VIDEK OK SOI I EIEI	X.	4200 WYNTREE DR				
BELL OA	AKS TERRACE		NEWB	URGH, IN47630			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
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TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
R0119	employee shall be facility by the sup- designee) of the comployee will work employees shall in (1) Instructions or specialized population (A) aged; (B) developmentation (C) mentally ill; (D) dementia; or (E) children; served in the facil (2) A review of the applicable proced (A) organization of (B) personnel poli (C) appearance at employees; and (D) residents' right (3) Instruction in for procedures, and for preparedness, incorprocedures. (4) Review of ethic confidentiality in reconfidentiality in reconsident to work of the confidentiality in reconsident to work of t	ity. e facility's policy manual and lures, including: chart; icies; nd grooming policies for its. irst aid, emergency					
	employee's personnel record by the person supervising the orientation.						
	Based on record	review and interview, the	R0119	Citation #5 R 119 410 IAC	09/20/2011		
	facility failed to	ensure employees		16.2-5-1.4 (d) (1) (A-E) (2) (4	• • • • • • • • • • • • • • • • • • •		
	received orientar	tion to the facility and that		(3- Personnel What correct action(s) will be accomplis			
	documentation of	of the orientation was		for those residents found t			
	maintained in th	e employee files for 7 of 7		have been affected by this			
				deficient practice? No resid			

were found to be affected.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITH	A. BUILDING 00			COMPLETED	
				B. WING			08/15/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	₹		l				
5511.04	TEDD 1 0E			l	YNTREE DR			
BELL OAKS TERRACE				l NEMRC	JRGH, IN47630			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	from employmen	nt since 4/22/11. (RN			Employee files were reviewe	d		
	1	or #2, CNA #1, CNA #2,			with building specific oriental	tion		
		4, PSA #1, RN Wellness			provided to current staff and			
					placed within their prospective			
	·	e deficient practice had the			employee file. How the facil	-		
	potential to affect	et 46 of 46 residents at the			will identify other residents	•		
	facility.				having the potential to be			
					affected by the same defici			
	Findings include	· ·			practice and what correctiv	e		
	i mamga merade	··			action will be taken? No			
					residents were found to be	_		
	During Entrance Conference with				affected. Employee files were			
	Residence Director (RD) #1 on 8/11/11 at				reviewed with building specit orientation provided to curre			
	10:30 a.m., files	of employees terminated,			staff and placed within their	"		
	either voluntarily	y or involuntarily, since			prospective employee file. W	/hat		
	4/1/11 were requ	•			measures will be put into p			
	4/ 1/ 11 Welle lequ	lested.			or what systemic changes			
		0/11/11 10.00			the facility make to ensure			
		v on 8/11/11 at 10:30			the deficient practice does			
	a.m., RD #1 pro	vided files of seven		recur? The Residence Director				
	employees termi	nated since 4/1/11.			and Wellness Director were			
	Review of the fi	les at this time indicated			re-educated to our policy and	d		
	lack of orientation	on and documentation of			procedure regarding new			
	orientation as fo				employee paperwork along v			
	orientation as to	nows.			completion of building specif	ic		
					orientation. The Residence			
		Director #2, date of hire			Director and/or Designee wil			
	7/21/11, lacked	orientation and			responsible for ensuring bui	~ 1		
	documentation of	of orientation to all			specific orientation is comple			
	required aspects	except mechanical			for employees and placed wi their prospective file.	u III		
		oleted by the Maintenance			How will the corrective action	(e)		
		sieted by the Manitenance			will be monitored to ensure th			
	Supervisor.				deficient practice will not recu			
					i.e., what quality assurance	<i>'</i>		
	2. CNA #1, date	e of hire 6/22/11, lacked			program will be put into place	.?		
	orientation and o	locumentation of			The Residence Director and/or			
	orientation to all	required aspects except			Designee will perform a randon	n		
	resident rights.	, r			monthly audit of employee files			
	1051delit 11giits.				period of six months to ensure s			

'		(X2) M	ULTIPLE CC	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
			B. WIN	IG		08/15/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
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BELL OA	KS TERRACE			NEWBU	JRGH, IN47630	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE
	3. CNA #2, date of hire 4/22/11, lacked				have building specific orientation completed and placed within the	
	orientation and d				employee file. Audits will be	
		required aspects except			reviewed after six months throu	gh
		orientation, signed by the			Bell Oaks Terrace QA process t	
		2/11, a former Residence			determine the need for an ongo	ing
		1, and a trainer whose			monitoring plan. Findings	14
	signature was no	t legible on 5/5/11.			suggestive of compliance will r in cessation of our monitoring p	
	4. CNA #3, date	of hire 6/8/11, lacked			By what date will the systemic	
	orientation and d				changes be completed?	
	orientation to all required aspects of orientation.				Compliance Date: Sept 20, 2011	.1
	5 CNA #4 date	of hire 4/28/11, lacked				
	orientation and d					
		required aspects of				
	orientation.	required aspects of				
	orientation.					
	6 DSA (Dersona	l Services Assistant) #1,				
	`	11, lacked orientation				
		on of orientation to all				
	required aspects					
	required aspects	or orientation.				
	7 PN Wellness	Director #1, date of hire				
		•				
	5/2/11, lacked or	f orientation to all				
		of orientation except for				
	job specific orien	nanon.				
	During intomii	at this same time. DD #1				
	_	at this same time, RD #1				
		s the Regional Residence				
		teen facilities in her				
	_	uding residences in				
	Tennessee, Kentu	acky, and Indiana. She				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 08/15/2	LETED	
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	transferred to an subsequently left employment. She provisional admining and had Oaks for about frindicated as conshomes, it was had this same interviful had not actual was suspended result behavior, and that terminated.	ne indicated she had a inistrator's license for been filling in at Bell four months. She sultant for fourteen and to keep up. During ew, RD #1 indicated PSA lly been terminated but elated to unusual at he would probably be intial finding is related to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/15/2011
	PROVIDER OR SUPPLIER		4200 W	ADDRESS, CITY, STATE, ZIP CODE YNTREE DR JRGH, IN47630	
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R0121	employee of a factor The screen shall in using the Mantous unless a previously documented. The millimeters of indudate read, and by facility must assur (1) At the time of equation (1) Month prior to annually thereafte personnel of facility tuberculosis. The must be read prior work. For health of had a documented test result during the months, the basel should employ the step is negative, a performed one (1) first step. The frequency depend on the risk tuberculosis. (2) All employees reaction to the skill have a chest x-ray laboratory examinal a diagnosis. (3) The facility shall a diagnosis. (3) The facility shall feach employee employment-related (4) An employee vactive disease, (sy active tuberculosis is rule based on record	employment, or within one employment, and at least r, employees and nonpaid ries shall be screened for first tuberculin skin test to the employee starting are workers who have not dengative tuberculin skin the preceding twelve (12) in tuberculin skin testing two-step method. If the first is second test should be to three (3) weeks after the tubercy of repeat testing will be of infection with the who have a positive in test shall be required to and other physical and ations in order to complete with symptoms or signs of all the ed health screenings. With symptoms or signs of an amount of the process of signs of the process of signs of the process of signs of the process of the process of signs	R0121	Citation #6 R 121 410 IAC 16.2-5-1.4 (d) (1) (A-E) (2) (A	09/20/2011 A-D)
	-			(3- Personnel What correct	ive

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C7RY11

Facility ID:

004903

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	DING	NSTRUCTION 00	(X3) DATE (COMPL 08/15/2	ETED	
	PROVIDER OR SUPPLIEF	<u> </u>	B. WING	STREET AI	DDRESS, CITY, STATE, ZIP CODE YNTREE DR RGH, IN47630	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
	received health a skin testing for t former employer from employmendeficient practice affect 46 of 46 reference to 10:30 a.m., files either voluntarily 4/1/11 were required buring interview a.m., RD #1 provemployees terming Review of the filther following embealth assessment tuberculosis (TB 1. RN Wellness 7/21/11 - no evice assessment or TI	assessments, including aberculosis, for 7 of 7 es hired and terminated at since 4/22/11. The e had the potential to esidents at the facility. Conference with tor (RD) #1 on 8/11/11 at of employees terminated, y or involuntarily, since tested. You on 8/11/11 at 10:30 wided files of seven nated since 4/1/11. The est at this time indicated aployees did not have the and/or skin tests for prior to employment: Director #2, date of hire dence of health			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) action(s) will be accomplish for those residents found to have been affected by this deficient practice? No residence were found to be affected. Employee files were reviewed with completion of health assessments, including skintesting for tuberculosis and placed within their employee How the facility will identify other residents having the potential to be affected by same deficient practice and what corrective action will taken? No other residents we found to be affected. Employ files were reviewed with completion of health assessments, including skintesting for tuberculosis and placed within their employee. What measures will be put place or what systemic changes will the facility matto ensure that the deficient practice does not recur? The Residence Director and Wel Director were re-educated to policy and procedure regard employee health screening, including skin testing for tuberculosis. The Wellness Director has developed and implemented a tickler book containing employee health screens, including mantoux	hed o dents dents de file. y the d be vere yee de file. into de file. i	
	health assessmer	of hire 4/22/11 - no at and no TB skin test. of hire 6/8/11 - no health			test to ensure continued compliance. How will the corrective action will be monitored to ensure the	n(s)	

004903

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED
		B. WING		08/15/2011
	PROVIDER OR SUPPLIER AKS TERRACE	STREET ADDRESS, C 4200 WYNTREE NEWBURGH, IN		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DD FFIY (EACH C	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
IAU	assessment, first step of TB skin test on 6/21/11, no second TB skin test. (CNA #3 was listed on the schedule as a housekeeper for 10 days on the daily schedule from 7/31/11 through 8/13/11.) 5. CNA #4, date of hire 4/28/11 - no health assessment and no TB skin test. 6. PSA (Personal Services Assistant) #1, date of hire 6/10/11 - no second step TB skin test. (PSA #1's last date scheduled for work was 8/7/11 on the schedule from 7/31/11 through 8/13/11.) 7. RN Wellness Director #1, date of hire 5/2/11 - no health assessment. During interview at this same time, RD #1 indicated she was the Regional Residence Director for fourteen facilities in her corporation, including residences in Tennessee, Kentucky, and Indiana. She indicated the RD from Bell Oaks had been transferred to another facility and had subsequently left the company's employment. She indicated she had a provisional administrator's license for Indiana and had been filling in at Bell Oaks for about four months. She indicated as consultant for fourteen homes, it was hard to keep up. During this same interview, RD #1 indicated PSA #1 had not actually been terminated but	deficience i.e., who prograte The Word Design month of the file for ensure will be through process ongoing suggest in cessare By what change	nt practice will not recur, at quality assurance am will be put into place? ellness Director and/or ee will perform a random y audit of employee tickle a period of six months to continued compliance. Au reviewed after six months a Bell Oaks Terrace QA is to determine the need for g monitoring plan. Finding tive of compliance will restation of our monitoring plant date will the systemic is be completed? iance Date: Sept 20, 2011	r dits an gs ult

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/15/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	behavior, and tha	elated to unusual at he would probably be ing investigation.					
	RD #1 indicated	on 8/11/11 at 3:00 p.m., the Wellness Director is B testing, and some have ne cracks."					
	This state resider Complaint IN000	ntial finding is related to 094485.					
R0144	state of good repa	Ill be clean, orderly, and in a ir, both inside and out, and onable comfort for all					
	facility failed to	ention and interview, the ensure residents' rooms in good repair for 5 of 5	R0144	Citation #7 R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards What corrective action(s) will be	09/20/2011		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7RY11 Facility ID:

004903

If continuation sheet

Page 25 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
			B. WIN			08/15/2	011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8		1	YNTREE DR		
BELL ∩/	AKS TERRACE			1	JRGH, IN47630		
				<u> </u>	51.G11, 11.47.000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	residents whose	rooms and bathrooms			accomplished for those		
	were inspected f	rom a sample of 15.			residents found to have be	en	
	(Residents F, K,	L, N and M)			affected by this deficient		
					practice? No residents were found to be affected. Reside		
	Findings include	••			K, L, N, and M had their roor		
	i mamgs merade	·•			professionally cleaned and	110	
	 En !n.m	1			repaired. How the facility w	ill	
		observations on 8/15/11			identify other residents hav		
	from 4:15 to 4:5	5 p.m., were as follows:			the potential to be affected		
					the same deficient practice	and	
	1. In the bathroom of Resident F, smears of a brown substance were observed on the floor in front of the toilet. Crumbs				what corrective action will	be	
					taken? No other residents w	ere	
					found to be affected. Reside		
		were on the floor of the			K, L, N, and M had their roor	ns	
	bathroom.	were on the floor of the			professionally cleaned and		
	batiliooni.				repaired. What measures w		
					put into place or what syste		
		om of Resident K, the			changes will the facility ma to ensure that the deficient		
	trash can was ful	ll to overflowing with			practice does not recur? The		
	soiled pull-ups.	The seat and inside of the			Residence Director and Well		
	toilet were soiled	d with a brown substance.			Director were re-educated to		
	A large dead bug	g was on the floor beside			policy and procedure pertain		
	1 -	een the open window and			cleaning of resident apartme	nts	
	1	ndow near the bed, a			and the Indiana state ruling I		
		,			410 IAC 16.2-5-1.5 (a) Sanit	ation	
	~	stance was observed on			and Safety Standards. The		
	the window facing	ngs.			Residence Director will be responsible to ensure contin	uod	
					compliance with resident cle		
	3. In the room of	of Resident L, gouges into			of apartments per our Reside	•	
	the drywall abov	e the baseboard near the			Agreement. The House keep		
	1 *	rved. Pieces of drywall			has developed and impleme		
		et. The carpet was soiled			a room cleaning list to be		
	1	ed debris. In the resident's			completed and reviewed with	n the	
					Residence Director and/or		
	bathroom, the toilet was smeared on the				Designee to ensure cleaning	prior	
		with a brown substance.			to end of shift. How will the corrective action	(e)	
		oor in front of the toilet			will be monitored to ensure th		
	was covered wit	h live, moving ants. No			win be monitored to ensure th	C	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
			B. WIN			08/15/2011
NAME OF	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP CODE	
				1	YNTREE DR	
BELL OAKS TERRACE				NEWBL	JRGH, IN47630	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	· ·		-	TAG	DEFICIENCY)	DATE
	1	available on the roller or			deficient practice will not recu	ır,
	beside the toilet.				i.e., what quality assurance program will be put into place	.,
					The Residence Director and/or	•
	4. In the bathroo	om of Resident M, the			Designee will perform random	
	coating on the fl	oor of the shower was			weekly review of apartments cl	
	chipped and pee	ling. A trash bag was			by the housekeeper for a period	of
	draped over the	side of the trash can			six months to ensure continued	200
	holding the bathroom door open. The				compliance with room cleanling per our expectation. Audits will	
	interior of the trash can was soiled with				reviewed after six months throu	
	splotches of a brown substance. The floor				Bell Oaks Terrace QA process t	·
	of the bathroom, especially in front of the				determine the need for an ongo	ing
	toilet and sink, was dull gray with scuffs.				monitoring plan. Findings	
	tonet and shik, was dan gray with seams.				suggestive of compliance will r	
	5 The carnet in	Resident N's room was			in cessation of our monitoring p	olan
	_	front of the television, in			By what date will the systemic	
	1	feet by 3 feet. The carpet			changes be completed?	
		n front of the resident's			Compliance Date: Sept 20, 201	1
	1 -	ned with large dark				
		loor of the resident's				
	bathroom was a					
	Janii Ooni was a	uun giay.				
	On 8/15/11 at 4:	55 p.m. Residence				
		2 arrived at the facility,				
	` ′	RD #3 arrived. RD #3				
	1	a on the facings between				
		screen of Resident K's				
	1	bed. During interview at				
	1	3 indicated the substance				
	1	ew. RD #3 wiped an area				
		ill inside the room and				
		dirty. RD #3 observed oor in Resident M's room				
		e dull gray was worn out				
	Inoleum. RD#	3 indicated the floors				I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
			B. WING		08/15/2011
NAME OF D	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	KOVIDEK OK SUI I EIEK		4200 W	YNTREE DR	
	BELL OAKS TERRACE			JRGH, IN47630	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
	-	because residents might			
	fall.				
	This state residen	ntial finding is related to			
	Complaint IN000	094001.			
	1				
R0145		II maintain equipment and			
		and operational condition			
	and in sufficient que the residents.	uantity to meet the needs of			
		ation, record review, and	R0145	Citation #8 R 145 410 IAC	09/20/2011
			K0143	16.2-5-1.5 (b) Sanitation and	• • • • • • • • • • • • • • • • • • •
		cility failed to ensure		Safety Standards What	"
	* *	n date and supplies were		corrective action(s) will be	
	sufficient for med	eting residents' needs for		accomplished for those	
	2 of 5 residents re	eviewed wearing		residents found to have be	en
	Wanderguard ale	rt bracelets (Residents O		affected by this deficient	
	•	46 residents whose care		practice? No residents were	<u>, </u>
	f f	of gloves/trash can		found to be affected. Reside	•
	liners.	or groves, trastream		& P had new wander guards	•
	inicis.			ordered and placed on resid	
	E. 1 1 1			The wander guard system w tested and found to be	a5
	Findings include:	:		operational. The Residence	
				ordered trash can liners and	
	1. On 8/11/11 at	11:20 a.m., the employee		gloves for staff utilization. He	
	file for PSA (Pers	sonal Services Assistant)		the facility will identify other	
	#1 indicated corr	espondence including,		residents having the poten	I
		o, an unsigned notation		to be affected by the same	
		ting, "[Name of PSA #1],		deficient practice and what	
		ssed the sufficient		corrective action will be tal	I
				No other residents were four	
	supplies of garba	ge bags and gloves and		be affected. Residents O & F new wander guards ordered	
				L Hew walluct gualus ofdered	anu

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4200 WYNTREE DR **BELL OAKS TERRACE** NEWBURGH, IN47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE placed on residents. The wander that you are to ask for them when cleaning guard system was tested and and they will be supplied to you...." found to be operational. The Another memo, from the corporation's Residence Director and/or Director of Human Resources to Designee will be responsible for ensuring ordering of resident Residence Director #3 (unlicensed) with supplies is completed timely and carbon copy to Residence Director #1 that trash can liners and gloves (Health Facility Administrator of record) are available for staff providing indicated, "...Please let him know we have resident care. What measures a sufficient supply of garbage bags and will be put into place or what systemic changes will the gloves...." facility make to ensure that the deficient practice does not During interview in regard to the gloves recur? The Residence Director and trash can liners, Residence Director and Wellness Director were (RD) #1 indicated the facility was without re-educated to our wander guard system and techniques to ensure gloves and trash can liners on one day. it is functioning properly. The RD #1 indicated she herself went to (a Residence Director and/or local department store) and purchased Designee will be responsible to gloves and liners on that day. RD #1 ensure the wander guard system is operational. The Residence indicated at that time she had an AIT Director will also be responsible (Administrator in Training) working with for ordering of supplies for her, who was responsible for supply caregivers and to ensure orders, and he had not ordered needed availability for resident care. How will the corrective action(s) supplies. will be monitored to ensure the deficient practice will not recur, During interview with Confidential i.e., what quality assurance Interviewee #1 on 8/11/11, the program will be put into place? interviewee indicated the facility had no The Residence Director and/or Designee will perform random gloves for resident care on the first day of monthly review of wander guard the job. Confidential Interviewee #1 system and caregiver supplies for a indicated gloves were purchased period of six months to ensure the personally by the interviewee for use in wander guard system is functioning the facility. properly and caregiver supplies are available for staff providing care for a period of three months to ensure During interview with Confidential

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2011			
	PROVIDER OR SUPPLIER		B. WING OO/ 13/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630				
	SUMMARY S (EACH DEFICIEN REGULATORY OR Interviewee #2 o interviewee indic gloves for provic care, and the face for about three w Confidential Inte gloves were som residents receivin hospice services other residents. During interview Interviewee #3 o interviewee indic than one day who without gloves. #3 indicated the were without glo During observati Residents F, K, a 4:15 p.m. and 4:: sign in bold lette walls of the resid supplies (gloves, chucks, etc.) are not use these on	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) In 8/11/11, the cated the facility had no ling residents' personal dity was without gloves reeks in July 2011. crviewee #2 indicated etimes borrowed from ing home health or for provision of care to with Confidential in 8/11/11, the cated there had been more en the facility was Confidential Interviewee re were several days they eves or trash can liners. on in the rooms of and G on 8/15/11 between 55 p.m., the following ring was posted on the lents' rooms: "All creams, diapers, wipes, paid for by hospice. Do other patients. Thank	4200 V	VYNTREE DR	ection AULD BE PROPRIATE Audits will be as through cocess to an ongoing ags ags awill result coring plan asstemic	(X5) COMPLETION DATE	
	RD #2 indicated this date, and no signs were poste	on 8/15/11 at 4:55 p.m., the signs were posted on one indicated why the d. RD #2 indicated the d not spoken to her about					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED 08/15/2011			
	PROVIDER OR SUPPLIER		B. WING OG/13/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630				
				-			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	the signs.	,					
	p.m., in regard to Wanderguard syst Director indicate Wanderguards for is good until the Marketing Direct the Wanderguard seated at this time near the facility's Marketing Direct the alarm was go heard it sound to was near the from the alarm at this expiration date on Director indicated date and needed Marketing Direct residents, includithe Wanderguard Observations we residents' Wanderguard Observations we residents' Wanderguard Observations we residents' Wanderguard Observations we residents' brack be out of date with 8/10.	stem, the Marketing d she checks dates on the or residents, and the alarm expiration date. The tor was asked to check for Resident O, who was e in the residence foyer alarmed front door. The tor indicated she knew bod, because she had just alert staff the resident at door. Observation of time indicated an f 8/10. The Marketing d the alarm was out of to be changed. The tor provided a list of five ting Resident O, who used alarm system. The made of all the reguard bracelets, and selet was also observed to the an expiration date of the indicated to 10094368, IN00094417,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER BELL OAKS TERRACE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630 ID PROVIDER'S PLAN OF CORRECTION				
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)			
R0214	each resident shall admission and shall semiannually and change in the reside often at the reside licensed nurse shall needs of the reside Based on record facility failed to attended to the massessment after reviewed related (Residents B and Findings include 1. The clinical reviewed on 8/11 Resident Service 9:00 p.m. indicate found sitting on the shall off the believed on the pressure 98.6 [to [respirations]. [Sinjuries noted @ notified - Dr. [nareceived - messal Dr. office. Res.]	review and interview, the ensure a licensed nurse ursing need for falls for 2 of 2 residents to falls in a sample of 15. Exercise to Free for Resident B was for the falls in a sample of 15. Exercise to falls in a sample of 15. Exercise for Resident B was for fall at 2:55 p.m. Is Notes on 7/13/11 at red, "Res. [resident] was fine side of her bed - states red side - walker in B/R roulse] 80 209/82 [blood emperature] 80 [pulse] 24 resymbol for no] apparent this X [time]. Family for me] notified - recording rege - incident report fax to red ying in bed at this X." In the fall of the fal	R0214	Citation #9 R 214 410 IAC 16.2-5-2 (a) Evaluation W corrective action(s) will be accomplished for those residents found to have I affected by this deficient practice? No residents we found to be affected. Resident we found to be affected interven minimize the risk for falls we injury. How the facility will identify other residents he the potential to be affected the same deficient practic what corrective action we taken? No other residents found to be affected. Residented considered at risk for falls reviewed with their service updated to include intervent to minimize the risk for fall injury. What measures wi put into place or what sy changes will the facility re to ensure that the deficie practice does not recur? Wellness Director and lice nursing staff were re-educe	hat be been ere dents B e plans tions to with II naving ed by ce and iiI be e were dents were e plans ntions s with II be stemic make nt The nsed		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WING			08/15/20)11
NAME OF	PROVIDER OR SUPPLIEF	}	5	STREET AI	DDRESS, CITY, STATE, ZIP CODE	-	
					/NTREE DR		
BELL OAKS TERRACE				NEWBU	RGH, IN47630		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		1	TAG	DEFICIENCY)		DATE
		in the Resident Services			our policy and procedure	ام ما	
	Notes failed to in	ndicate a nurse was			regarding our fall response a protocol. The Wellness Direct		
	notified or asses	sed the resident.			and/or Designee will evaluate		
					residents who are considered		
	2. The clinical r	ecord for Resident F was			risk for falls to ensure		
		1/11 at 3:15 p.m. Resident			interventions are noted on th	e	
	1	on 7/27/11 at 7:40 p.m.,			service plans in order to mini	mize	
	1	was found on floor - side			the risk for falls with injury.		
	1				How will the corrective action	` ′	
of bed - sts [states] she's [symbol for not]					will be monitored to ensure the		
in pain ROM [range of motion] performed					deficient practice will not recu i.e., what quality assurance	г,	
[[symbol for no] apparent injuries noted					program will be put into place	,	
	VS [vital signs]" The note also				The Wellness Director and/or	.	
	indicated the physician, family, hospice				Designee will perform random		
	provider, admini	strator and nursing staff			weekly review of incident report	rts	
	l -	d. The note was signed			and the service notes for a period		
		ocumentation in the			six months to ensure residents v		
	1 * 1	es Notes failed to indicate			experience a fall and/or change		
	a nurse assessed				condition are assessed by a licensed		
	a nurse assessed	the resident.			nurse to ensure they have appro interventions noted on their serv	_	
		0/10/11 + 5.10			plans to minimize the risk for a	vice	
	1 -	v on 8/12/11 at 5:10 p.m.,			potential adverse event. Resider	nts	
	1	tor (RD) #2, from a sister			will be assessed by the Wellness		
	facility and filling	ng in for RD #1, indicated			Director on a routine basis utiliz		
	she would expec	et a resident to be sent out			our Nursing Comprehensive	-	
	for evaluation at	the time of a fall, if the			Assessment in order to evaluate		
	resident hit the h	lead, or if an emergency			formulate a plan to minimize th		
	1	-1 would be called. RD		- 1	for a potential adverse event base		
	1	other situations, the nurse		- 1	on the assessment of the individual scheduled and unscheduled need		
		ed to come into assess a		- 1	Audits will be reviewed after size		
	1	ls. RD #2 indicated if the		- 1	months through Bell Oaks Terra		
		e floor, he should remain		- 1	QA process to determine the ne		
		*			an ongoing monitoring plan.		
	1	I the nurse arrives, but if			Findings suggestive of complian	nce	
		sts on getting up, the			will result in cessation of our		
		ess the resident as soon as			monitoring plan		
	she arrives on si	te.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WING		08/	15/2011	
NAME OF F	PROVIDER OR SUPPLIER	•	STRE	ET ADDRESS, CITY, STATE,	, ZIP CODE		
THE OF I	RO VIDER OR SOLVER		4200) WYNTREE DR			
BELL OA	KS TERRACE		NEV	VBURGH, IN47630			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED T			
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	NCY)	DATE	
D0015	(a) F allowing a comm			By what date wil changes be comp Compliance Date	oleted?		
R0217	facility, using appromembers, shall ide services to be prov	oletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as					
	follows: (1) The services of resident shall be a	ffered to the individual ppropriate to the:					
	(A) scope;						
	(B) frequency; (C) need; and						
	(D) preference;						
	of the resident.						
	(2) The services of	ffered shall be reviewed					
		propriate and discussed by					
	the resident and fa	acility as needs or desires					
	•	facility or the resident may					
	request a service p						
		on service plan shall be					
		by the resident, and a copy					
		shall be given to the					
	resident upon requ	n and documentation of					
		is needed if evaluations					
		initial evaluation indicate no					
	need for a change						
	_	n of medications or the					
	` '	ntial nursing services, or					
	both, is needed, a	licensed nurse shall be					
		cation and documentation of					
	the services to be	•					
		review and interview, the	R0217	Citation #10 R 2		09/20/2011	
	facility failed to	ensure the resident's		16.2-5-2 (e)(1-5)	•		
	•	signed by the resident or			What corrective action(s) will be accomplished for those		
	1 1 1	. The facility also failed		residents found to have been			
	to ensure a nurse	participated in planning		affected by this	deficient		
	services for resid	ents who required		practice? No re			
	nursing care. The	e deficient practice		found to be affe	cted. Residents		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	A. BUILDING 00			COMPLETED	
				B. WING			11	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	R		1				
5511.01	TEDD 4.0E		4200 WYNTREE DR					
BELL OF	AKS TERRACE			NEMBC	JRGH, IN47630			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	affected 4 of 6 r	esidents whose service			C, D, B, and E had their serv	rice		
	plans were revie	wed related to signatures			plans reviewed by the			
	1 -	B, and E), and 1 of 6			interdisciplinary team with pl	ans		
					implemented to meet these			
		service plans were			clients scheduled and	The		
		to nurse participation			unscheduled needs. are met service plans were signed by			
	(Resident C) in	a sample of 15.			appropriate parties as indica			
					within our policy and procedu			
Findings include: 1. The clinical record for Resident C was					How the facility will identify			
					other residents having the			
					potential to be affected by	the		
					same deficient practice and			
	reviewed on 8/11/11 at 4:05 p.m. The				what corrective action will			
	1	rice plan, dated 8/8/11,			taken? No other residents w	ere		
	was signed by R	esidence Director (RD)			found to be affected. What			
	#1. No signatur	e of the			measures will be put into p	lace		
	resident/respons	ible party or nurse was			or what systemic changes	will		
	1	plan indicated the resident			the facility make to ensure	I		
	1	services including		the deficient practice does not				
	1	s and medication			recur? The Wellness Directo	I .		
	1	s and medication			and Residence Director were			
	administration.				re-educated to our policy and procedure regarding the serv			
					level assessment and negoti			
	2. The clinical i	record for Resident D was			service plan. The Residence			
	reviewed on 8/1	1/11 at 3:35 p.m. The			Director will ensure the servi			
	most recent serv	rice plan, dated 7/6/11,			level assessment is signed b			
		D #3, the Residence			appropriate parties as indica			
	1 -	ning, and a nurse. No			within our policy and proced			
	1	~			How will the corrective action			
		resident/responsible party			will be monitored to ensure th			
	was indicated.				deficient practice will not recu	ır,		
					i.e., what quality assurance	,		
	3. The clinical i	record for Resident E was			program will be put into place	er		
	reviewed on 8/11/11 at 2:15 p.m. The most recent service plan, dated 5/11/11,				The Residence Director and/or			
					Designee will perform random weekly reviews of service			
		n AIT [Administrator in			assessments for a period of six			
		-			months to ensure appropriate			
	-	nurse. No signature of the			interventions are discussed thro	_{iigh}		
	resident/respons	ible party was indicated.			mici ventions are discussed thro	ugii		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		08/15/2011	
NAME OF F	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE		
			I	WYNTREE DR		
BELL OA	KS TERRACE		NEWI	BURGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				our interdisciplinary team with		
	4. The clinical re	ecord for Resident B was		appropriate signatures obtained for a period of six months. Audits will be		
	reviewed on 8/11	/11 at 2:55 p.m. The		reviewed after six months throu		
	most recent servi	ce plan, dated 5/5/11,		Bell Oaks Terrace QA process	-	
	was signed by the	e AIT and the former RN		determine the need for an ongo		
	Wellness Directo	r #1. No signature of the		monitoring plan. Findings		
	resident/responsi	ble party was indicated.		suggestive of compliance will i		
	•	1 ,		in cessation of our monitoring	plan	
	On 8/15/11 at 5:2	20 p.m., RD #2, RD #3,		By what date will the systemic		
	and the RN Wellness Director #3, whose first day on the job was 8/15/11, were			changes be completed?	,	
				Compliance Date: Sept 20, 20	11	
	observed in the nurse's station looking					
		and stacks of documents.				
	_	at this time, RD #3				
	_					
		opies of the service plans				
	-	urse's station, but no				
	•	d. RD #3 indicated				
		er signs for him, but had				
	not signed the mo	ost recent plan.				
D0241	(a) The administra	tion of medications and the				
R0241		ntial nursing care shall be				
		resident 's physician and				
		d by a licensed nurse on the				
	premises or on cal					
	, ,	all be administered by				
	medication aides.	ersonnel or qualified				
		ation, record review and	R0241	Citation #11 R 241 410 IAC	09/20/2011	
		cility failed to ensure	10271	16.2-5-4 (e)(1) Health Service	''' ''	
		medications were		What corrective action(s) w		
	_	ordered by the physician		be accomplished for those		
		its reviewed related to		residents found to have be	en	
	101 2 01 6 residen	us reviewed related to		affected by this deficient		
				practice? Resident C had the	ie	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4200 WYNTREE DR **BELL OAKS TERRACE** NEWBURGH, IN47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE physician's orders in a sample of 15. dressing changes clarified with the hospice nurse with (Residents F and C) documentation to be provided as to the scheduled dressing Findings include: changes as ordered by the physician. Resident C was assessed utilizing the pain 1. During observation of personal care on assessment scale with physician 8/12/11 at 10:20 a.m., CNAs #5 and #12 notification as to appropriate pain assisted Resident F to the toilet. As the management. Resident F had the CNAs assisted the resident to remove her medication regimen reviewed with the licensed staff as to brief, runny yellow stool was observed on appropriate intervention to be the brief. The resident was seated on the implemented with episodes of toilet and defecated again. During loose stools. Resident F's interview at that time, CNA #12 indicated physician was also notified by the Wellness Director of the episodes the resident had often had diarrhea for of loose stools for possible quite some time, and she wondered if intervention. How the facility will maybe the resident's medications caused identify other residents having the diarrhea. the potential to be affected by the same deficient practice and what corrective action will be The clinical record for Resident F was taken? No other residents were reviewed on 8/11/11 at 3:15 p.m. The found to be affected. What record indicated an order was received measures will be put into place 7/8/11 by the hospice nurse for or what systemic changes will Immodium 2 mg by mouth after each the facility make to ensure that the deficient practice does not loose stool for a maximum of 16 mg per recur? The Wellness Director day. On 7/22/11 a physician's order, still and licensed staff were current for August 2011, indicated, re-educated to our policy and "Immodium 2 tab TID [three times daily] procedure regarding our Medication Administration prn [as needed] for diarrhea." Record, medication administration, and The MAR for August 2011 indicated the documentation. The Wellness resident had received no doses of the Director will ensure the medication administration record Immodium during that month. and service notes indicate medications and treatments are During interview on 8/15/11 at 5:20 p.m.,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
			B. WING		08/15/2	2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 WYNTREE DR NEWBURGH, IN47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	QMA #1 indicate four weeks since Immodium. RN looked at the Me Record and indic Immodium most 2A. During obse for Resident C or the resident was dressings on the on a coccyx wou dressings were drecent dressing complete the clinical recording received by the hout was not limit [symbol for change & R [right] anterfollowed [sic]: One in the complete the cover with Telfa with] paper tape healed." The Treatment A July 2011 failed	Resident F had Wellness Director #3 dication Administration rated the resident had recently on 7/16/11. Ervation of personal care in 8/12/11 at 10:35 a.m., robserved to have right and left shins and ind. None of the rated for the date of most hange. In displaying the displa		administered as indicate the physicians order. Ho the corrective action(s) monitored to ensure the deficient practice will note., what quality assurate program will be put into the Wellness Director and Designee will perform raweekly review of the Me Administration Record as service notes for a period months to ensure medicand treatments are administrated by the physic period of six months. Auber eviewed after six monthrough Bell Oaks Terract process to determine the an ongoing monitoring prindings suggestive of compliance will result in of our monitoring plan. Becompleted? Compliance Sept 20, 2011	will be e ot recur, ance o place? nd/or ndom dication nd the d of six ations inistered ician for a dits will onths ce QA e need for lan. cessation y what changes		
l	and left legs.	completed to the right					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE				
			B. WIN	G		08/15/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			4200 WYNTREE DR				
BELL OAKS TERRACE				NEWBU	JRGH, IN47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
		s note, dated 7/28/11,					
	indicated, "Revie	ewed dressing [symbol					
	for change] order	rs with [name of LPN					
	#1]No dressing	g [symbol for change]					
	has been done sin	nce last HRN [hospice					
	registered nurse]	visit. [LPN #1] agreed					
	to address matter	. "					
	2B. During the observation of personal care for Resident C on 8/12/11 at 10:35						
	a.m., CNAs #5 and #12 indicated she "just						
	· ·	bothered." CNA #12					
		the resident when they					
		resident was observed to					
		's fingers and not want to					
	_	rolled from side to side					
	~						
	*	nsing. As the resident					
	_	bed, she grimaced,					
		d, "You don't know how					
	bad that hurts."						
	Desident Cl. 1	olician and ann Carl A					
		sician orders for August					
		e following medications					
		ntin, 10 mg, twice daily;					
	' '	two tablets every four					
		for pain; and Oxycodone					
		lution, 0.25 ml (5 mg) by					
		he tongue every hour as					
	needed for pain of	or shortness of breath.					
	The August 2011						
		Record indicated neither					
	of the "as needed	" medications had been					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
			B. WING		08/15/2011
NAME OF P	PROVIDER OR SUPPLIER		l l	DDRESS, CITY, STATE, ZIP CODE	
BELL ∩∆	KS TERRACE			YNTREE DR JRGH, IN47630	
		TATEMENT OF DEPOSITNOIS			(2/5)
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	administered in A	August 2011.			
R0407	(b) The facility must control program the (1) A system that is analyze patterns of symptoms. (2) Provides orient education on infectincluding universal (3) Offering health including, but not litransmission and in (4) Reporting combealth authorities. Based on observatinterview, the fact planned infection mechanism was analyzing pattern deficient practice affect 46 of 46 referred from the fact of the	st establish an infection at includes the following: enables the facility to of known infectious tation and in-service tion prevention and control, I precautions. Information to residents, imited to, infection mmunizations. Indicate the disease to public action, record review and cility failed to ensure the incontrol tracking completed timely for its of infections. The enhas the potential to estidents in the facility.	R0407	Citation #12 R 407 410 IAC 16.2-5-4 (e)(1) Health Service What corrective action(s) where we will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected. The infection control log was implemented for August by the Wellness Director as indicated within the form. How the fact will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected. What measures will put into place or what systechanges will the facility many many services.	rill en ne ed ility ent e uer ll be emic

004903

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		DING	00	COMPLETED		
			B. WING	G		08/15/20)11	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
IVAIVIE OF TROVIDER OR SUITELER				4200 WYNTREE DR				
BELL OAKS TERRACE			NEWBURGH, IN47630					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	·		DATE	
	each document was: "Please make note of any new abx [antibiotic] below. Month:				to ensure that the deficient			
				practice does not recur? The Wellness Director and licensed				
	[on one blank document was June Yr:				staff were re-educated to our policy and procedure regarding our infection control log to ensure			
	2011; on one was July Yr: 2011, and on a							
	third was: August Yr: 2011]."							
					we are tracking and trending the			
	During observation in the nurse's station on 8/11/11 at 4:40 p.m., LPN #1 was			infectious processes identified on				
					a monthly basis. The Wellne			
				Director will be responsible to ensure the infection control log is updated when residents are identified as having an infection.				
	observed completing the blank logs for							
	June, July, and August, 2011. During							
	interview at this time, LPN #1 indicated			How will the corrective action(s) will be monitored to ensure the				
	she had just completed the logs for tracking infections. During interview on 8/11/11 at 5:00 p.m., Residence Director (RD) #1 indicated LPN #1 had just completed the logs for the past three months with information by reviewing short term change in condition reports. RD #1 was requested to provide the facility's current Infection Control policies.							
					deficient practice will not recur,			
				i.e., what quality assurance				
				program will be put into place? The Wellness Director and/or Designee will perform a random				
					weekly review of the Infection Tracking Log to ensure continued			
					compliance for a period of six months. Audits will be reviewed after six months through Bell Oaks			
				Terrace QA process to determine the need for an ongoing monitoring				
						g		
					plan. Findings suggestive of			
The facility's po		licy for Infection Control			compliance will result in cessat	ion of		
	was requested and was provided on the conference room table on 8/12/11 at 9:15 a.m. The policy failed to describe the system for how infections were to be tracked.				our monitoring plan. By what date will the systemic changes be completed? Compliance Date: Sept 20, 2011			
	u ackeu.							